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DISABILITY COMPENSATION DIVISION

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INSTRUCTION SHEET FOR WC-2 TEST FORM, PHYSICIAN'S REPORT

General Filing Information

Please refer to sections 386-96, Hawaii Revised Statutes; 12-10-61, Hawaii Administrative Rules; and 12-15-80, Medical Fee Schedule Administrative Rules, for statutes and rules regarding filing of the WC-2, Physician's Reports.

1. Section 386-96, HRS, provides filing requirements for the WC-2 Form.

   A. **Initial Report (**Pages 1 and 2 of the WC-2 Test Form) must be filed within seven days after the date of first treatment to the Department of Labor and Industrial Relations (DLIR) with the office on the island of injury as indicated on page 2 of this instruction sheet and to the employer's workers' compensation insurance carrier/adjuster. If there is no insurance carrier/adjuster, send the completed WC-2 Test Form to the "delinquent employer" and to the DLIR, Disability Compensation Division (DCD) at the address on the island of injury as indicated on page 2 of this instruction sheet.

   B. **Interim Reports** to the same parties at appropriate intervals. (See no. 2 below)

   C. **Final Report** (Pages 1 and 2 of the WC-2 Test Form) to the same parties as in "A" above shall be filed within seven days after termination of treatment.

2. Section 12-15-80, Medical Fee Schedule Administrative Rules, requires that the **interim WC-2** reports be filed monthly, with the corresponding billing invoice, if applicable, to the employer's workers' compensation insurance carrier.

   A. File pages 1 and 2 of the WC-2 Test Form for initial and final reports and whenever there is a change, i.e. change in diagnosis, change in treatment plan, change in condition, etc.

B. File <u>Attachment A, Functional Status Form (WC-2A Test Form), and/or Attachment B, Psychological Status Form (WC-2B Test Form)</u>, whichever is applicable, <u>once a month</u> to the insurance carrier. If there is no change in condition from the previous WC-2 report, pages 1 and 2 of the WC-2 Test Form are not required every month.

3. Note: If the patient is released to modified or regular work, please inform the patient to immediately notify the employer of the release to work status.

4. It is important that the insurance carrier be promptly notified of the patient's disability dates in order to pay indemnity benefits on a timely basis.

Delivery by U.S. Mail, In-Person, or via Fax

Oahu	Kauai	Maui
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813 Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766 Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street #2 Wailuku, Hawaii 96793 Phone: (808) 984-2072 Fax: (808) 984-2071
Hawaii	**West Hawaii**	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakekua, Hawaii 96750 If Mailing, Please Mail to This Address: P.O. Box 49, Kealakelua, Hawaii 96750 Phone: (808) 322-4808 Fax: (808) 322-4813	

Instructions For Completing WC-2 Test Form And Attachments

General Case Information

DCD Case Number	Enter the Disability Compensation Division's workers' compensation case number.
Employer's Name and Address	Enter the Employer's name and current or last known address.
Carrier's/Adjuster's Name, Address, and Telephone No.	Enter the Insurance Carrier's or the Insurance Adjuster's Company name, address, the phone number and the name of the adjuster working on the case (if known).
Patient's Name and Address	Enter the Patient's First Name, Middle Initial, and Last Name as shown on the employee's social security card, and their current home address, including city, state, and zip code.
Physician's Name, Address, and Telephone No.	Enter your name, address, and telephone number.
Carrier's Claim #	Enter the Insurance Carrier's Claim Number (if any) (Not DCD Case No.)
Physician's Tax ID # or Lic. #	Enter your physician's tax identification number or State of Hawaii License Number.
Date of Injury/Illness	Enter the date of injury or illness or "on or about" date if exact date is not known. Use the format, **mm/dd/yy**, to indicate the numerical month, day and year.
Date of First Treatment	Enter the date you initially treated the patient for the industrial injury/illness. Use the format, **mm/dd/yy**, to indicate the numerical month, day and year.
Accident Description	Enter the description of the industrial injury/illness stating in the patient's own words where and how the accident occurred, and the part of the body injured.
Type of Report	Place a "check" in the appropriate box to indicate if this is a first report, first and final report, interim report, final report, or treatment plan.

Diagnosis

ICD-9CM Code or CDT Code	Enter the diagnosis code.
Description and Body Part	Enter a brief description of the injury/illness and indicate what part(s) of the body were injured. Enter if the industrial accident/illness is the only cause of the patient's condition. If not, enter other reasons for the patient's condition.
Current Complaints/ Disability Status/ Date Released to Work	**Enter the patient's current complaints and current medical status. Indicate date of surgery (if applicable); dates totally disabled from work due to the industrial injury/illness; date released to modified duty and restrictions; date released to regular duty.**

Prognosis

Recovery	Place a "check" in the appropriate box if full recovery is anticipated, full recovery is not anticipated, or if it is undetermined at this time.
Maximum Medical Improvement/Medical Stability	Enter the date you anticipate the patient will be at maximum medical improvement and medically stable.
Permanent Impairment Expected	Place a "check" in the appropriate box to indicate if the patient may have any permanent impairment resulting from the industrial injury/illness.
Disfigurement Size	Enter measurements of disfigurement (length, width, etc.)
Location/Description	Enter the body location and description of the disfigurement.

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Patient Name; DCD Case Number, D/A, Carrier Claim Number	Enter the patient's full name, Disability Compensation Division's (DCD) Case Number, date of accident (D/A), and Carrier's Claim Number (if known).

Proposed Treatment Plan

Start and End Date	Enter the start and end date(s) of the treatment plan.

Estimated Cost	Enter the estimated cost of treatment under the proposed treatment plan.
Physician	Enter any prescribed medications, treatment, and procedures.
Type of physician	Place a "check" in the appropriate box to indicate what type of physician you are. Physicians as defined in section 386-1, HRS, include persons who are licensed to practice medicine, dentistry, chiropractics, osteopathy, naturopathy, optometry, podiatry and psychology.
Visit Frequency	Enter the frequency of treatment indicating how often you plan to treat the patient.
Non-Physician	Enter the name, address, phone, and procedures of the provider of service other than a physician who treats or will treat the patient for the industrial injury/illness. Place a "check" in the appropriate box to indicate if the non-physician is a physical therapist, occupational therapist, or other type of provider of service. For "other", please specify, i.e., massage therapist, acupuncturist, etc. Enter the frequency of treatment(s) and any specific instructions.
Guidelines	Place a "check" in the box if your treatment is within evidenced-based/best practices guidelines. If other than evidenced-based/best practices guidelines, please provide an explanation or description.
Diagnostics	Place a "check" in the appropriate box to indicate if any X-ray, CT scan, MRI, EMG, or Other diagnostic treatment(s) is necessary. Indicate the area of the body to be treated and why the diagnostic treatment(s) are necessary, and what will be ruled out (R/O).
Referral Requests	Place a "check" in the appropriate box to indicate if any additional referrals are necessary. For consults and concurrent treatment, please enter the name, specialty, and purpose of the consult or concurrent treatment.
Work Station Evaluation Needed	Place a "check" in the box if the patient's work station needs evaluation to accommodate the patient's injury/illness.
Patient Stopped Treatment	Enter if and when the patient stopped treatment without any orders.

Current Findings and Measurable Objectives

Job of Injury Occupation	Enter the patient's occupation and a brief description of the job of injury, and enter the name of any additional employers (concurrent employment) and the occupation and brief description of any additional job(s).
Current Restrictions	**If there are any current restrictions resulting from the industrial injury/illness, please complete the appropriate Status Form:** **Attachment A for physical restrictions.** **Attachment B for psychological restrictions.** **Other.**
Measurable Objectives	**Describe timeline for improvement in functional levels. Please indicate your goal to increase the patient's functional status level (indicate what level the patient is at and what level your treatment will achieve) by what specific date.**
Prior Objectives Met?	Place a "check" in the appropriate box to indicate an improvement in the patient's condition showing that your prior objectives were met or not, or whether there has been **no** change in patient's condition. List any comments you may have.
Visual Analog Pain Scale	Upon observing the patient, on a scale of 1 through 10, with 10 being the most pain, enter your estimated pain measurement. What is your goal in reducing the patient's pain level?
Comments	List any comments and/or concerns you have in this area. Also attach dates of treatment, related chart notes, results of any tests during this reporting period.
Physician Signature	Sign, print your name and phone number, and date the WC-2 Test Form and place a "check" in the appropriate box to indicate whether you are the attending physician or not for this industrial injury/illness. If you are not the attending physician, please indicate the name of the attending physician.

Instructions for Attachment A, Functional Status Form (WC-2A Test Form)

Enter patient's name, date of injury (DOI), and DCD's Case and Carrier's Claim Numbers at the top of Attachment A. Answer questions 1 to 3 at the top of Attachment A.

Section A is to assess an employee's ability to perform the most basic activities of daily living, specifically the nonmaterial handling activities of sitting, standing, and walking, including the material handling activities of lifting and carrying.

Place a "check" in the appropriate box to indicate how many **minutes at one time** the patient is able to sit, stand, and walk.

Place a "check" in the appropriate box to indicate the total **hours per day** the patient can sit, stand and walk.

Place a "check" in the appropriate box to indicate the **maximum pounds** the patient may lift and/or carry.

Section B addresses restrictions of specific activities that may be required based on the nature and location of an employee's injury. Complete **Section B** of **Attachment A**, if applicable, only if the patient has additional limitations not mentioned in **Section A**. Place a "check" in the appropriate column showing the amount of time the patient is able to do the additional activity. List other activities not listed on the form in the "Other" section.

Section C addresses the length of time the restrictions will be in effect and the physician's goals in improving the patient's injury/illness due to the industrial injury. In **Section C**, indicate the dates the functional status limitations/restrictions will be in effect.

Sign, print your name, list your phone number, and date.

Instructions for Attachment B, Psychological Status Form (WC-2B Test Form)

Enter patient's name, date of injury (DOI), the DCD Case Number, and the Carrier Claim Number at the top of Attachment B.

1. List the patient's diagnosis.

2. Check the appropriate line to indicate if this is the initial report or not.

3. Indicate change in functional status from the last report you did and describe the changes.

4. Indicate if the mental disorder under treatment arose out of or was exacerbated by the patient's employment.

5. Indicate if the patient is able to return to work and the date able to return to work. If not able to return to work, indicate the last date the patient worked.

6. Indicate whether there are limitations for the patient to perform their usual and customary work due to a mental disorder related to the industrial injury. Specify what are the limitations. (i.e., patient cannot return to work for the same employer due to stress caused by co-worker or boss.)

   Indicate if the patient is able to return to their usual and customary work at a different work site. (i.e., patient is able to work in a different section of the company or for a new employer.)

7. Indicate and list other factors, if applicable, that may affect the patient's return to work ability, which are not part of the industrial mental disorder injury. (i.e. pre-existing conditions, frustration, anger, etc.) Indicate and explain whether these other factors are the reason the patient is unable to return to work.

8. Indicate what is the patient's prognosis.

9. Indicate date when the patient will be at maximum medical improvement.

10. List any comments you have.

11. **Sign, date, print your name, and list your phone number**.